Link to Final Agency Decison
OAH Docket No. 3-0900-17245-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HEALTH

In the Matter of Lake Winona Manor, Abbreviated Standard Survey Exit Date: February 15, 2006

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) meeting conducted by Administrative Law Judge Kathleen D. Sheehy on June 26, 2006, at 1:00 p.m. at the Office of Administrative Hearings. The OAH record closed at the conclusion of the meeting on June 26, 2006.

Marci Martinson, Unit Supervisor, Division of Facility and Provider Compliance (DFPC), 1645 Energy Park Drive, Suite 300, St. Paul, MN 55108-2970, appeared on behalf of DFPC. Mary Cahill, Planner Principal of the Division of Compliance Monitoring, also attended the meeting.

Susan M. Schaffer, Orbovich & Gartner, Historic Hamm Building – Suite 417, 408 St. Peter Street, St. Paul, MN 55102-1187, appeared on behalf of Lake Winona Manor (the facility). The following persons made comments on behalf of the facility: Mary Miller-Hyland, NHA, Administrator; Patti Volkman, RN, Director of Nursing; and Paula Walter, RN, former Nurse Manager.

FINDINGS OF FACT

1. Lake Winona Manor, located in Winona, Minnesota, is a skilled nursing facility with approximately 154 beds.

2. Resident #1, an 81-year-old female, was admitted to the facility on December 19, 2005, after a hospital stay for a hip fracture.[1] She had a primary diagnosis of end-stage renal disease and needed renal dialysis three times per week, as well as physical and occupational therapy. She also suffered from hypertension, hypothyroidism, osteoarthrosis, coronary atherosclerosis, hyperlipidemia, gastroenteritis, and colitis. Resident #1 had several drug allergies, including codeine, ibuprofen, and morphine.[2] Despite all her medical conditions, she had a clear mind and was able to speak and communicate well.

3. Resident #1 required extensive assistance with dressing, toileting, and personal hygiene, and she was totally dependent on facility staff for bed mobility, transferring, and locomotion.[3] She was also on a therapeutic diet with fluid restrictions.

4. On December 19, 2005, upon her admission to the facility, facility staff performed a visual assessment of the Resident's skin.[4] No pressure sores were observed.

5. Because of the Resident's allergies to other medications, her physician prescribed one to two tablets of Lortab every six hours as needed for pain. In addition, the Resident could take Extra-Strength Tylenol every four hours.

6. On December 20, 2005, the facility gave Resident #1 three doses of Lortab before the Resident's family expressed concern that the drug was causing Resident #1 to become confused. The family asked the facility to discontinue the Lortab and use only the Extra Strength Tylenol. The facility complied with this request.

7. By December 24, 2005, the Resident was experiencing severe pain again, and the facility administered Ultram, a stronger pain medication that the Resident had tolerated well in the past.[5] Resident #1 took the Ultram for two days before complaining that the drug made her overly drowsy. On December 26, 2005, at the request of the family, the Ultram was discontinued.

8. Interdisciplinary notes dated December 24, 2005, indicated that the Resident's buttocks were very dry and sore. The notes state that the Resident was encouraged to allow staff to reposition her every two hours to prevent pressure sores. The notes also indicate that she experienced moderate pain daily.[6]

9. The Resident was resistant to being repositioned due to the pain in her hip, and she frequently went over onto her back after the facility staff finished repositioning her on her side. Facility staff encouraged her to stay on her side.

10. The Minimum Data Set for this Resident, dated December 28, 2005, indicated the Resident had no pressure sores, that no turning or repositioning program was in place, and that the Resident was not using pressure-relieving devices in her bed or chair.[7]

11. On December 28, 2005, facility staff completed a Braden Scale skin risk assessment to determine the Resident's risk for pressure sores.[8] The assessment categorized Resident #1 as having a low risk of pressure sore development.[9] The facility notes from later that night indicated that the Resident's coccyx was reddened with a moderate size darkened area that was intact.[10] Facility staff applied a dressing to the reddened area that day.

12. By the afternoon of December 29, the Resident's sore was open, blackened, and draining a small amount of fluid. Clean bandages were reapplied. Staff spoke to the Resident and her spouse about the importance of staying off her bottom. Physical therapy brought a cushion for her wheelchair.[11] By that evening, there were four areas on and around her coccyx that were open, blistering, and necrotic. On December 31, 2005, the sore had a foul odor and a significant amount of drainage.[12] A facility nurse wrote in the Resident's dialysis

notes for December 31 that Resident #1 should be repositioned during dialysis because of an ulcer on her coccyx.[13]

13. By January 2, 2006, the sore had created a deep crater in the Resident's back (stage 3 ulcer). Staff applied an ointment, but the Resident complained of a burning sensation and asked that it be removed. On January 3, 2006, during repositioning, Resident #1 yelled out in pain. The nursing staff continued to administer extra strength Tylenol for pain relief. The Resident said the Tylenol was effective, but the Resident continued to scream when anyone touched her leg. She wanted to stay in bed for breakfast because of the pain. The Resident was seen by a skin care specialist that day.[14] By January 5, 2005, nursing notes indicate the Resident's leg and bottom were very painful and that the Tylenol was not taking care of her pain.[15] A note to the Resident's physician in her dialysis notebook on January 5 stated that the Tylenol was not taking care of the Resident's severe pain and asked if there was another medication she could try.[16] The physician did not respond to the inquiry and the facility did not follow up on the request.

14. On January 6, 2006, about two thirds of the coccyx wound was covered with thick, dark eschar. Facility staff left a message with the skin care specialist asking about debridement of the wound.[17]

15. On January 7, nursing notes indicate her leg was very sore and repositioning was very painful. The pressure sore was oozing and foul.[18]

16. On January 8, 2006, the Resident was in excruciating pain and could not sit up. Facility staff consulted with her doctor and obtained another prescription for Ultram. It was not effective in relieving her pain.[19]

17. By the end of the day on January 8, the facility consulted with the Resident's husband and daughter, who requested that the Resident be taken to the emergency room. Resident #1 was admitted to Community Memorial Hospital in Winona early that evening.[20] After undergoing surgery to debride the wound, the Resident continued to decline. She died on January 14, 2006. The cause of death was sacral abscess and cellulitis secondary to her left hip fracture.[21]

18. Shortly thereafter, the DFPC began the investigation that resulted in the abbreviated standard survey at issue in this proceeding.

Based upon the exhibits submitted and the arguments made, and for the reasons set out in the Memorandum that follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

1. That the citation with regard to F-tag 309 is supported by the facts and should be affirmed as to scope and severity.

2. That the citation with regard to F-tag 314 is supported by the facts and should be affirmed as to scope and severity.

Dated: July 14, 2006.

s/Kathleen D. Sheehy
KATHLEEN D. SHEEHY
Administrative Law Judge

Reported: Taped, one tape
No transcript prepared

NOTICE

Under Minn. Stat. § 144A.10, subd.16 (d)(6), this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

MEMORANDUM

The DFPC abbreviated standard survey completed February 15, 2006, was the result of a complaint investigation conducted to determine if the facility failed to provide adequate pain management and adequate prevention of and treatment of pressure sores to Resident #1. Two inter-related deficiencies resulted.

Tag F 309

Federal law requires that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care."[22] "Highest practicable" is defined as the highest level of functioning possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline.[23]

Where there is a lack of improvement or a decline, surveyors must determine if the occurrence was avoidable or unavoidable. A determination that a decline was unavoidable can only be reached if the facility has an accurate and complete assessment of the resident, a care plan which is implemented consistently and based on information from the assessment, and an evaluation of the results of any interventions and revision of the interventions as necessary.

The DFPC argued that while Resident #1 experienced increased pain, up to the level of 10 on a scale of 10, the facility did not respond in an aggressive manner to find a medication that would effectively control her pain. As a result, the DFPC asserted that the Resident continued to experience severe pain and ultimately suffered actual harm as defined by the State Operations Manual (SOM).[24] The DFPC determined that the deficient practice cited under this regulation was isolated and created actual harm that did not rise to the level of immediate jeopardy.

The facility argued that Resident #1 was comprehensively assessed upon her arrival at the facility, and that the care plan was a result of discussion with the Resident and interviews with her family members that was consistent with the Resident's wishes. The facility argued further that the survey findings gave an incomplete description of the Resident's complex medical condition and the facility's efforts to manage her pain. The facility requests that the findings regarding Resident #1 in F309 be removed or, at a minimum, that the severity score be lowered.

The record shows that the facility did not consistently monitor the Resident's pain and the degree to which the pain medications were effective. Because of the pain, the Resident resisted repositioning. While it was acceptable for the facility to go along with the family's wishes about the Resident's pain medication initially, the family should have been consulted and the course of treatment revised once the pressure sore developed and caused the Resident additional discomfort. Sending a note to the dialysis physician, to which no response was made, is insufficient to show the facility revised pain interventions as necessary.

The Administrative Law Judge concludes that the facility has not presented sufficient evidence to demonstrate that the results of the survey were incorrect or that the Resident's decline was unavoidable. Based upon the facility's records, the surveyors reasonably determined that the facility failed to provide the necessary care and services to the Resident to attain or maintain her highest practicable physical, mental, and psychosocial well-being. Tag F 309 should be affirmed as to scope and severity.

Tag F 314

Based upon a resident's comprehensive assessment, the facility must ensure that (1) a resident who enters a facility without pressure sores does not develop pressure sores unless the resident's clinical condition demonstrates that the sores were unavoidable, and (2) a resident with pressure sores receives the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.[25]

A pressure sore is "avoidable" if the facility failed to do one or more of the following: (1) evaluate the resident's clinical condition and pressure ulcer risk factors; (2) define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; (3) monitor and

evaluate the impact of the interventions; or (4) revise the interventions as appropriate.[26]

Because pressure sores can develop so quickly, the facility should have a system in place to assure that each resident is assessed promptly and completely. A thorough assessment should address the resident's intrinsic risks, the resident's skin condition, other factors which place the resident at risk of developing pressure sores (i.e., decreased mobility, impaired blood flow, resident refusal of treatment, under nutrition, and dehydration), and the nature of the pressure to which the resident may be subjected via a skin integrity and tolerance test.[27]

The DFPC argued that the assessment completed by the facility on December 19, 2005, did not include an assessment of the Resident's tissue tolerance to determine how long the Resident could lie in one position or sit in a chair without adverse effects to her skin. According to the DFPC, the assessment also did not include interventions that would have been helpful while the Resident was undergoing dialysis. Furthermore, the DFPC noted that there was no evidence that the Resident or her family were consulted to develop alternative interventions when the Resident refused to be repositioned.

The facility responded that Resident #1 was assessed as at-risk for skin breakdown, preventive measures were implemented, and that prevention of such breakdown was complicated given her significant co-morbidities. The facility further asserted that the pressure sore that developed on the Resident was the result of an injury that occurred prior to her admission at the facility and was therefore unavoidable. The facility also cited a study that concluded that "[p]ressure ulcers, a type of skin death, frequently occur in persons with a heavy disease burden, especially those at or near the end of life, despite good care."[28]

The Administrative Law Judge acknowledges the difficulty of this situation. Because of the Resident's pain, she did not tolerate being repositioned. And while the facility did implement a repositioning schedule, that schedule was not tailored to the Resident's individual needs based on the required tissue tolerance test. Furthermore, the record does not reflect that the facility made the Resident or her family aware of the importance of aggressively managing her pain so that she could tolerate repositioning and avoid the development of pressure ulcers.

The Administrative Law Judge concludes that the facility has not presented sufficient evidence to demonstrate that the results of the survey were incorrect. Based upon the facility's records, the surveyors reasonably determined that the facility failed to conduct the skin pressure test and that a pressure sore developed, which ultimately contributed to the Resident's death. Tag F 314 should be affirmed as to scope and severity.

[1] Ex. H-1.
[2] *Id*.
[3] Ex. H-5.
[4] Ex. 4, p. 82.
[5] Ex. 4, p. 111.
[6] Ex. H-31.
[7] Ex. H-7.
[8] Ex. H-18.
[9] The Braden Scale uses mobility, friction, activity, nutrition, sensory perception, and moisture as factors in determining the risk of developing pressure sores. Ex. H-18.
[10] Ex. H-33.
[11] Ex. H-32.
[12] Ex. H-33.
[13] Ex. H-72.
[14] Ex. H-34.
[15] Ex. H-36.
[16] Ex. H-72.
[17] Ex. H-37.
[18] *Id*.
[19] Ex. H-37.
[20] Ex. H-37.
[21] Ex. I-19.
[22] 42 C.F.R. § 483.25.
[23] Ex. D-1.
[24] The SOM defines "actual harm" as requiring a finding of noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and /or reach her highest practicable physical, mental, and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. It does not include a deficient practice that only could or has caused limited consequence to the resident.
[25] 42 C.F.R. § 483.25(c).
[26] Ex. G-2.
[27] Ex. G-7.
[28] Ex. 16.